CHAPTER 4 — CHANGES TO ENROLLMENT AND COVERAGE

401 Dual-Choice Enrollment

Dual-Choice enrollment provides an annual opportunity for **currently insured subscribers** to change from one health plan to another, or change from single to family coverage without a waiting period for pre-existing medical conditions.

A. Enrollment Period

The Group Insurance Board sets the Dual-Choice Enrollment period, normally a three-week period in October. Changes in coverage take effect January 1 of the following year.

B. Enrollment Eligibility

Two requirements must be met to make a change during Dual-Choice:

1. The employee must be currently insured in the Wisconsin Public Employers Group Health Insurance program; and

2. The *Group Health Insurance Application* (ET-2301) must be received by the employer during the designated Dual-Choice Enrollment period.

C. Distribution of *It's Your Choice* booklets (ET-2128)

It's Your Choice booklets must be distributed in a timely manner to all insured employees, including employees who indicate they do not wish to make a change during Dual-Choice and employees on temporary layoff or leave of absence.

D. Employees Initially Eligible for Coverage on November 1 or December 1

Employees who are initially eligible for coverage on November 1 or December 1, and who wish to change to a different health plan or coverage type effective January 1 must file two applications during their regular enrollment period. The first application will cover the period from the date of initial coverage through December 31. The second application changes them to whatever health plan or coverage type is desired effective January 1, and must have the "Dual-Choice" box checked as the reason for submitting the application.

E. Employee coverage ends after submitting a Dual-Choice Election.

- List current health plan on *Continuation-Conversion Notice* (ET-2311) (if coverage ends prior to December 31.

- List Dual-Choice elected health plan on *Continuation-Conversion Notice* if current coverage ends on or after December 31.

F. Special January Reporting Instructions for Dual-Choice

1. Report in alphabetical order, the employees electing to switch health plans on the *Monthly Deletions Report* (ET-2612) for the health plan they are switching from. Refer to Subchapter 503 for instructions on completing the *Monthly Deletions Report*.

2. Report in alphabetical order, the employees electing to switch health plans on the *Monthly Additions Report* (ET-2610) for the health plan they are switching to. Refer to Subchapter 502 for instructions on completing the *Monthly Additions Report*.

402 Withdrawing Dual-Choice Elections

Employees may rescind Dual-Choice elections by notifying their employers in writing prior to December 31 of the same year. Upon receipt of the written request to rescind, employers must make four photocopies of the employer copy of the *Group Health Insurance Application* (ET-2301) initially submitted by the employee during Dual-Choice and write "Rescind" across each copy. Immediately forward one copy to the current health plan, one copy to the health plan indicated as the new health plan selected, and one copy to ETF. Retain the last copy, along with the employee's written request to rescind, for the employer's records. Note: No application for coverage may be rescinded on or after the effective date of coverage. After the coverage effective date, the rescind becomes a cancellation.

403 When a Health Plan is not Available at Dual-Choice

When a health plan is no longer available for the upcoming year, subscribers enrolled in that plan must submit a *Group Health Insurance Application* (ET-2301) during the Dual-Choice Enrollment period to enroll in a new health plan. Subscribers are notified by letter from the departing health plan at the onset of Dual-Choice. Subscribers who do not submit an application during the Dual-Choice Enrollment period may only change to the Standard Plan to continue coverage. Coverage is effective the first day of the calendar month on or after the date the employer receives the application.

404 Late Dual-Choice Applications

Subscribers may request a review by ETF if they believe they were not offered a Dual-Choice opportunity and/or they feel that their *Group Health Insurance Application* (ET-2301) should be accepted after the Dual-Choice Enrollment period. The steps included in this process are as follows:

1. Employee submits application after end of Dual-Choice enrollment period.

2. Employer rejects and returns late application to employee with instructions on requesting a review. A sample letter informing an employee of this process is found in Subchapter 405.

3. Employee submits written request for review to the employer no later than January 31 following the Dual-Choice Enrollment period.

4. Employee includes in the written request the facts or circumstances of the review request including the remedy being sought.

5. Employer develops a cover memo addressed to ETF detailing the process used to distribute Dual-Choice materials to employees, the date of receipt of the employee's Dual-Choice application, and any pertinent facts related to the employee's review request.

6. Employer sends a **copy** of the employee's Dual-Choice *Group Health Insurance Application*, the original letter of request for review from the employee, and the cover memo to:

   DIVISION OF TRUST FINANCE & EMPLOYER SERVICES
   EMPLOYEE TRUST FUNDS
   P O BOX 7931
   MADISON WI 53707-7931

7. ETF reviews the materials submitted and issues a letter within 60 days to the employee, copying the employer, approving or denying the request.

405 Dual-Choice Review Sample Letter

Below is a sample letter from the employer informing an employee of the review process for a Dual-Choice application that is filed late.

(DATE)

(EMPLOYER NAME AND ADDRESS IF NOT ON THE LETTERHEAD)

Dear (EMPLOYEE NAME):

Your Dual-Choice health application is being returned to you by our office because it was not received timely. You may request a review of your late application by the Department of Employee Trust Funds through the following process:

- Prepare a written request detailing the circumstances and facts surrounding the reason for your late application and the remedy being sought.

- **Submit your written request to our office at the address noted above by January 31.** Do not submit your request directly to the Department of Employee Trust Funds.

- We will review your request for completeness and attach any pertinent supporting documentation.

- We will submit your request, your health application, and other supporting documentation to the Department of Employee Trust Funds for review.

- The Department of Employee Trust Funds will review the materials and issue you a letter approving or denying the request.

If you have questions, please contact (NAME) at (TELEPHONE NUMBER).

406 Switching Health Plans Following Residential Move

A subscriber who has a residential move to another county for a minimum of three months has an enrollment opportunity to switch health plans, even if the current health plan remains available in the county to which the subscriber moved. (A move from one medical facility to another medical facility by the subscriber is not considered a residential move.) To change health plans, the relocating subscriber must submit a *Group Health Insurance Application* (ET-2301) to the employer within 30 days after the move.

If the relocating subscriber wants to change health plans and does not submit an application within 30 days after the move, the subscriber and all covered dependents can submit a late application but are limited to the Standard Plan with a 180-day waiting period for pre-existing conditions. The subscriber may change health plans during an upcoming Dual-Choice Enrollment period.

If the relocating subscriber wants to remain with the same health plan, the subscriber should complete the *Health Insurance Information Change* (ET-2329) indicating the residential address change. (Refer to Subchapter 408.)

407 Adding/Deleting Dependents

A. Adding a Dependent.

A dependent may become eligible due to marriage, birth, adoption or placement for adoption, or regaining eligibility status. Submit documentation for additions due to adoption.

1. A subscriber enrolled in single coverage may add a newly eligible dependent by submitting to the employer a completed *Group Health Insurance Application* (ET-2301). Coverage is effective on the date of birth, adoption, placement for adoption, or marriage if the application is submitted within 60 days of the birth, adoption or placement for adoption, or within 30 days of a marriage. A full month's premium for family coverage is due for that month if family coverage is effective before the 16th of the month. Otherwise the family premium amount goes into effect for the following month.

2. A subscriber enrolled in family coverage must add a newly eligible dependent by submitting to the employer a *Health Insurance Information Change* (ET-2329). The form should be submitted within 60 days of the birth, adoption or placement for adoption, or within 30 days of a marriage.

3. A subscriber can add a previously ineligible dependent that regains eligibility. To add the dependent, a subscriber enrolled in single coverage must submit to the employer a *Group Health Insurance Application* and a subscriber enrolled in family coverage must submit a *Health Insurance Information Change*. The application or change form must be submitted within 30 days of the dependent regaining eligibility with coverage effective the date eligibility was regained.

B. Deleting a Dependent.

Dependent children lose eligibility for reasons such as reaching a certain age (i.e., age 25, or age 19 and not a full-time student), full-time student status ceasing, marriage, and ceasing to be dependent on either parent or guardian for support and maintenance. A spouse and stepchildren lose eligibility due to divorce. To ensure the right to continuation coverage is not lost, a loss of eligibility must be reported to the employer within 60 days of the later of (1) the event that caused the loss of coverage, or (2) the end of coverage. (Refer to Chapter 7 for information on continuation and conversion coverage.)

1. A subscriber who continues to be eligible for family coverage (i.e., has remaining eligible dependents) must submit to the employer *a Health Insurance Information Change* deleting the ineligible dependent.

NOTE: Employers should verify there are remaining eligible dependents upon receipt of the change form. If there are none, the employer should reject the change form and provide the subscriber with a *Group Health Insurance Application* for completion.

2. A subscriber who no longer has eligible dependents must submit to the employer a completed *Group Health Insurance Application* changing from family to single coverage. The change in coverage will be effective the first of the month following the loss of eligibility, except in the case of divorce or as determined by ETF in unique situations. (Refer to Subchapter 703 for information about divorce.)

408 Completing the *Health Insurance Information Change* Form (ET-2329)

Both the employee and employer have a role in completing the *Health Insurance Information Change* form. (A sample follows this subsection.)

Employee

1. Complete Sections 1 through 5 of the form and return it to employer:

   - Section 1 must be completed.
   - Section 2 must be completed only when the subscriber is reporting one or more of the following changes:
     - Name change
     - Address change
     - Home or daytime phone number change
     - Adding the social security number for a dependent
     - Changing the selected physician or clinic
     - Updating information about other insurance coverage
   - Section 3 must be completed only when **adding** a dependent and documentation attached where specified.
   - Section 4 must be completed only when **deleting** a dependent.
   - Section 5 must be completed.

Employer

2. Upon receipt of this form, verify that the subscriber sections are completed appropriately and supporting documentation is attached when indicated.

3. Complete the bottom section of the form ensuring codes entered are consistent with most recent forms filed:

a. Employee Type - enter the appropriate code. (Refer to subchapter 1103.)
b. Coverage Code - the type of coverage selected. (Refer to subchapter 1102.)
c. Two-digit Carrier Suffix identifying the health plan (carrier) (carrier suffixes appear on *Monthly Coverage Reports*) in which the subscriber is enrolled.
d. Participant County code identifying the county in which the subscriber resides. (Refer to subchapter 1101.)
e. Physician County - code identifying the county in which the subscriber's selected physician or clinic is located. (Refer to subchapter 1101.)
f. Program Option Code - identifies the program selected. (Refer to subchapter 1105.)
g. Surcharge Code - identifies the surcharge amount, if any. (Refer to subchapter 1107.)
h. Name of Employer.
i. Employer Number - the employer identification number (EIN) given to employers, beginning with 69-036. Enter the last seven digits of the number (e.g., 69-036-**9999-000**).
j. Five-digit Group Number - the first digit is the number 7, followed by the four-digit segment of the EIN (e.g., **79999**).
k. Date Received by Employer - the month, day and year the employer received the completed form. It is important this date be accurate in order to determine eligibility for continuation.
l. Monthly Employee Share - the amount the employee contributes toward the monthly premium for the health plan selected. (Refer to subchapter 302.)
m. Monthly Employer Share. The amount the employer contributes toward the monthly premium for the health plan selected. (Refer to subchapter 302.)
n. Date Employment Began - the month, day and year the employee began employment with the employer. For rehired employees, enter the rehire date.
o. Event Date - the month, day and year of the event which is the reason for submitting the form.
p. Prospective Date of Coverage - the month, day and year the change in coverage should be effective. (Refer to subchapter 303.)
q. Payroll Representative Signature acknowledging the employer received and audited the form.
r. Telephone number of the employer representative who signed the form.

4. Retain the employer copy and give the employee copy to the employee.

5. Immediately send the Carrier copy directly to the health plan and the ETF copy to ETF. This form does not have to accompany the regular monthly report(s) described in Chapter 5.

409 *Health Insurance Information Change* Form (ET-2329)

Department of Employee Trust Funds
Group Health Insurance
P.O. Box 7931
Madison, WI 53707-7931

HEALTH INSURANCE INFORMATION CHANGE

This form is to be completed by a subscriber who is only revising relevant information. Transactions such as changing HMOs or changing from single to family coverage require a new health application (ET-2301) and should not be submitted on this form.

SUBSCRIBER: Complete Sections 1-5. Return form to employer (or ETF if an annuitant).

1. Name _____ Birthdate _____ Social Security Number _____
   Health Insurance Plan _____ Present Coverage: ☐ Single ☐ Family
   Subscriber #_____ Group #_____
   (If retiree or continuant)
   I was a dependent or spouse of (name): _____ Social Security Number _____
2. Check the box(es) indicating the type(s) of change(s): Event Date _____
   ☐ Name change (list former name) _____
   ☐ Address change to: Street: _____
   County _____ City: _____ State: _____ Postal Code: _____
   ☐ Home Phone #_____ ☐ Daytime Telephone #_____
   ☐ Social Security Number _____ for _____
   ☐ Selected physician or clinic change to: _____ for _____
   Change in subscriber's physician or clinic county? ☐ No ☐ Yes, county is _____
   ☐ Update other insurance coverage for: _____
   Through State of WI, including University of WI? ☐ No ☐ Yes Name of Insured _____
   Insurance Company _____ Name of Employer _____
   Group # _____ Subscriber/Policy # _____ Effective Date _____ Medicare? ☐ No ☐ Yes
3. Complete the following when **adding** a dependent, please list the event date in the grid below *(applicant relationship code on reverse side)*:
   Reason: ☐ Marriage ☐ Student Status Changed ☐ Birth ☐ Legal Ward* ☐ Adoption* ☐ Disabled
   **Please attach documentation for additions due to legal ward or adoption status*
   Is spouse State of WI employee, including University of WI? ☐ Yes ☐ No

Last Name	First	Middle	Birthdate Mo	Da	Yr	Sex	Social Security Number	Applicant Rel. Code	Selected Physician or Clinic Last Name	First	Event Date

Dependents include spouse and children. Children include those who are dependent upon you and/or the other parent for at least 50% of their support, meet the support tests as a dependent for federal income tax purposes and are your natural children, legal wards who become your permanent ward prior to age 19, adopted children, stepchildren, or children of your dependent child until your child reaches age 18.

4. Complete the following for **deleting** a dependent. Please list the event date in the grid below:
   [Do not use this form to remove last dependent. Please complete new health application (ET-2301) to change to single coverage.]
   Reason: ☐ Divorce ☐ Age* ☐ Dependent Married ☐ Student Status Changed ☐ Legal Ward Relationship Ends
   **Dependent turned 19 and is not a full-time student; full-time student turned 25; grandchild of a dependent that turned 18.*

Last Name	First	Middle	Birthdate Mo	Da	Yr	Sex	Social Security Number	Event Date	Dependent's Address (If different than subscriber's)

NOTE: THE DELETION OF A DEPENDENT DUE TO LOSS OF ELIGIBILITY PROVIDES AN OPPORTUNITY FOR CONTINUATION COVERAGE (COBRA) UP TO 36 MONTHS PROVIDED NOTICE IS GIVEN TO THE EMPLOYER WITHIN 60 DAYS OF EVENT.

5. I have read and understand the Terms and Conditions on the reverse side. →
   Subscriber Signature _____ Date _____

EMPLOYER COMPLETES AREA BELOW Coding Instructions are in the Employer Health Insurance Manual

Enrollment Type	Employee Type	Coverage Code	Carrier Suffix	Participant County	Physician County	Program Option Code	Surcharge Code
65							

Name of Employer	Employer Number	Group Number	Date Received by Employer (MM/DD/CCYY)
	69-036-		

Monthly Employee Share	Monthly Employer Share	Date Employment Began (MM/DD/CCYY)	Event Date (MM/DD/CCYY)	Prospective Date of Coverage (MM/DD/CCYY)
$	$			

Payroll Representative Signature	Telephone
	( )

ET-2329 (REV 07/2005)

410 Changing from Active to Annuitant Coverage

Retiring insured employees are eligible to continue health coverage under any of the following conditions: (Refer to Chapter 8)

- Employee receives a retirement (monthly or lump sum), WRS disability, or Long-Term Disability Insurance benefit.

- Employee terminates after age 55 (50 for protective category employees) with at least 20 years of creditable WRS service, but does not take an immediate retirement annuity.

When a retiring employee qualifies for health insurance coverage and the employer continues to pay all or part of the monthly health insurance premium, for example, through conversion of unused sick leave, the retiring employee is considered an Employer-Paid Annuitant. Refer to Chapter 6 for information on monthly reporting requirements for Employer-Paid Annuitants.

When an employee retires, the employer must report it on the *Monthly Deletions Report* (ET-2612) deleting the employee from active status and on *the Monthly Coverage Report*. Refer to Subchapter 503 for instructions on completing *the Monthly Deletions Report* and Subchapter 505 on completing the *Monthly Coverage Report*.

411 Voluntarily Canceling Coverage

A subscriber can voluntarily cancel coverage at any time by submitting a *Group Health Insurance Application* (ET-2301) to the employer and checking "Cancellation" as the reason for submitting the application. The cancellation will be effective the last day of the month in which the employer receives the application or a later date as specified on the cancellation notice. Voluntary cancellation of coverage does not provide the employee and dependents an opportunity for continuation or conversion of the group coverage, which is described in Chapter 7.

The employer must report the cancellation on the appropriate month's *Monthly Deletions Report* (ET-2612). Under no circumstances is a partial month's premium refunded.

412 Enrollment/Coverage Change Effective Date Reference Chart

SITUATION	FORM DUE DATE	EFFECTIVE DATE OF CHANGE
DUAL-CHOICE	Application due during the annual Dual-Choice Enrollment period as described in Subchapter 401.	January 1 of the following year.

SITUATION	FORM DUE DATE	EFFECTIVE DATE OF CHANGE
MARITAL STATUS CHANGE	Application (if changing from family to single or single to family coverage) or change form (if no change in coverage) due within 30 days after marriage, or 60 days of the divorce, or being widowed. Be sure to indicate the date of occurrence in the "Event Date" box.	• For an employee who is first becoming eligible for family coverage because of marriage, coverage becomes effective the date of marriage. • For divorce, spouse's and stepchildren coverage ceases at the end of the month in which the divorce is granted or notification is received, whichever is later. • For widow(er), the change is effective at the end of the month in which the death occurred. See Chapter 7 on continuing coverage in divorce and surviving spouse situations.
ADDING A DEPENDENT	Application (if changing from single to family or family to single coverage) or change form (if no change in coverage) due within 60 days of date of birth, adoption or placement for adoption. Documentation of adoption or placement for adoption must be provided.	Date of birth or date child placed for adoption.
MOVE TO ANOTHER COUNTY	Application due within 30 days of subscriber's relocation to another county.	First of the month following employer's receipt of application. This is a change in health plan only. There are no waiting periods for pre-existing conditions. The level of coverage can change only if a qualifying event (i.e., birth, marriage, etc.) accompanies the relocation.
VOLUNTARY CHANGE TO SINGLE COVERAGE	Application due within 30 days of change.	Effective first of the month following change if no eligible dependents exist; otherwise, the first of the month following employer's receipt of the application.
CHANGE TO FAMILY COVERAGE	If first becoming eligible for family coverage, or if already eligible for family coverage but single coverage is in effect, application is due within 30 days of marriage or within 60 days of the birth, adoption, or placement for adoption. Be sure to indicate the event date.	The date the change in family status occurred. If the application is submitted after the enrollment period, change to family coverage is available only under the Standard Plan and a 180-day waiting period for pre-existing conditions applies to the spouse and/or dependent children.

SITUATION	FORM DUE DATE	EFFECTIVE DATE OF CHANGE
COVERAGE LAPSED DURING LEAVE OF ABSENCE	Application is due within 30 days after returning to work.	Reinstate the same level of coverage through the health plan in effect prior to the leave with coverage becoming effective the first of the month on or following the employer's receipt of the application. If the leave encompassed the **entire** Dual-Choice Enrollment period, the subscriber is eligible for a Dual-Choice election.
SINGLE CONTRACT IN EFFECT, NO ELIGIBILE DEPENDENTS – DEPENDENT REGAINS ELIGIBILITY DUE TO FULL-TIME STUDENT STATUS	Application due within 30 days of uninsured dependent's enrollment (date classes begin) as full-time student. (Note: Dependent must be otherwise eligible, i.e., meet support and maintenance requirements and is unmarried.)	Family coverage is effective the date of enrollment (date classes begin) as full-time student if completed application is received within 30 days.
REINSTATEMENT AFTER COMPLETION OF ACTIVE MILITARY SERVICE	Application due within 30 days of return to employment. Must have had coverage prior to entry in military and return to work within 180 days of release from active military service.	The level of coverage for the health plan in effect at the time of the military leave will become effective on the date of re-employment. In the event the subscriber is on leave during the entire Dual-Choice Enrollment period, the subscriber will be given a Dual-Choice enrollment opportunity. (Employee may change coverage level if a qualifying event occurred while on military leave.)
STANDARD PLAN	Application due anytime.	Employees can select the Standard Plan at anytime with coverage effective the first of the month following the employer's receipt of the application. Coverage will be subject to a 180-day waiting period for pre-existing conditions.
LOSS OF OTHER COVERAGE, INCLUDING EMPLOYEE WHO LOSES ELIGIBILITY FOR MEDICAL ASSISTANCE	Application due within 30 days of loss of eligibility for other coverage. Application must be accompanied by documentation that includes date the coverage is lost.	The effective date is the day following the expiration date of the former policy. Employee should be reported on the next monthly reports with adjustments, if applicable. If coverage begins after the 15th of the month, the premium is waived for that month. In all other cases, a full month's premium is due.